



Recommendations to improve abortion coverage and transparency in marketplace plans

By Fabiola Carrión

Abortion is a common health care intervention, as one in four women in the United States below the age of 45 will have at least one abortion in their lifetime.¹ The negative health and well-being impacts of abortion restrictions are well documented.² Studies show that when low-income individuals cannot access abortions, they are four times more likely to fall into poverty than individuals who are able to pay for that care.³ Abortions at ten weeks gestation cost \$500 on average, rising significantly later in pregnancy. For low- and middle-income individuals, this prohibitive amount forces them deeper into poverty. Individuals who are forced to continue a pregnancy are also more likely to experience serious complications like eclampsia and death in the final stages of their pregnancy, as well as suffer anxiety and loss of self-esteem after giving birth.⁴

As such, insurance coverage for abortion is critical for a person's wellbeing and economic stability. Unfortunately, several states do not permit abortion coverage in Medicaid, the marketplaces, and/or private plans.⁵ Research shows that even when no bans on abortion coverage exist, insured individuals do not always know about abortion coverage in their private and marketplaces plans.⁶ Thus, it is not sufficient that health care plans cover abortions; they must also clearly describe how they cover the abortions.

Following the release of [Beyond the Law: The Challenge of Abortion Coverage in the Marketplaces](#), various state advocates and commercial plans asked the National Health Law Program for more detailed recommendations on how plans can improve abortion coverage and how they communicate such coverage to potential and current enrollees. Below we suggest measures that states and insurers can take under existing legal requirements (advocates could seek to advance policies under both categories).

I. Advocacy for State Action

States should require all health plans to cover abortions. Qualified health plans (QHPs) should cover abortions at all metal levels (i.e. bronze, silver, gold, platinum) in every county of the state. In addition, states should continuously work with QHPs to make sure they offer the most comprehensive abortion coverage possible. Coverage should be available irrespective of the type of abortion intervention that patient wants and needs – medication, aspiration, or surgical. Additionally, states should:

- Prohibit prior authorization requirements for abortions because they are time-sensitive and essential services,
- Prohibit lifetime or yearly limits for abortion coverage, and
- Prohibit or limit cost-sharing requirements since deductibles and co-payments are often difficult to meet or pay.

If states do not already have these policies in place, they should either enact new legislative mandates or update their Essential Health Benefits benchmark plans to include abortions.⁷

States that mandate abortion coverage in all their QHPs should take additional steps to improve existing coverage and require how plans communicate this coverage to consumers. First, they should require that QHPs employ uniform and consistent terminology and definitions in all plan documents, including the Summaries of Benefits and Coverage (SBC) and Evidence of Coverage. State health care departments and insurance commissioners should require that SBCs use the word “abortion,” in contrast to “termination of pregnancy.” Individuals are likely to search for the word “abortion” when checking whether plans cover them.⁸ Second, states should prohibit QHPs from including in plan documents confusing distinctions like “elective,” “therapeutic,” or “voluntary” because the definitions to these concepts often vary among plans and are often stigmatizing for the person seeking abortion care. Abortions are health care services, making them medically necessary to anyone who requests them.

States should also require where plans describe abortion coverage in their SBCs. As described in Appendix 1, abortions should be featured in the Pregnancy Services or “If You Are Pregnant Now” Section and under the “Common Medical Events” column. Further, states should go beyond the federal requirement to make SBCs available at the time of enrollment and make them always public. SBC webpages should be always open to the public and in multiple languages. Potential enrollees, current enrollees, and anyone who wants to learn about abortion coverage should have access to these documents prior to, during, and after enrollment. In sum, states should make sure that SBCs are accessible, accurate, informative, and helpful sources for current and potential enrollees in QHPs as well as the general public.

States that do not mandate abortion coverage should ensure that their QHPs comply with current federal standards; in other words, they must clearly explain in their plan documents whether they include or exclude abortion coverage. Even when no coverage mandate exists, these states can certainly make sure that QHPs employ consistent terminology and definitions across all plan documents as explained above.

States that prohibit abortion coverage should work with QHPs to inform all enrollees that the state restricts insurance coverage of abortion services in the marketplaces. Conversely, if a state repeals its prohibition on abortion coverage, the state should widely disseminate information about such repeal and the opportunity for coverage.

II. Advocacy for Qualified Health Plan Action

In accordance with federal law, qualified health plans must clearly establish in their Summary of Benefits and Evidence of Coverage whether abortions are covered or not.⁹

In states where abortion coverage is not prohibited, QHPs should cover all types of abortions because they are essential health care services.¹⁰ Unless the state prohibits abortion coverage and plans are not religiously-affiliated, QHPs should not distinguish among abortions, for example choosing to cover only abortions that are the result of rape or incest or where the pregnant individual's life is in danger. NHeLP's research found that many QHPs were unnecessarily employing Hyde Amendment restrictions in their plan documents.¹¹ Qualified Health Plans should not impose limits to rape, incest, or life endangerment unless a state prohibition exists. They should cover all abortions equally and for any reasons - whether they are the result of rape, incest, whether the pregnant person's life or health is in danger, whether there is a pregnancy diagnosis, or simply because pregnant individuals decide to have abortions.

As described above, QHPs should cease from employing subjective and confusing terms like "elective," "therapeutic," or "voluntary" in plan documents. NHeLP's research found that one qualified health plan could define "therapeutic abortion" as meaning when the health of the pregnant individual is at risk, while another plan considers "therapeutic abortions" as those that occur in circumstances of rape and incest.¹² The use of such distinctions is stigmatizing, misleading, and should be strongly discouraged. Nevertheless, if plans use any coverage distinctions, they need to clearly and consistently define these concepts in all plan documents. Qualified health plans should also not place restrictions like lifetime or yearly limits on covered abortions.

Qualified health plans should list abortions in their list of “Common Medical Events,” and not isolate these services in the “Other Covered Services” section of the SBCs. Consumers will not likely look at that section to check whether their plan covers abortions. Further, consumers could interpret the “Other Covered Services” section as a section that does not health care services, when abortions are health care services.

Qualified health plans should list abortions under the pregnancy services section or under “If You Are Pregnant Now” category because individuals who become pregnant have two choices: to continue their pregnancies or to terminate them. Thus, “abortion services” would be appropriately listed as one of the services individuals may need if they are pregnant. Summaries of Benefits and Evidence of Coverage should list abortions on a separate row and on their own so that enrollees will have the information they need to make their health plan choice.

Individuals shopping for QHPs as well as current QHP enrollees should have access to basic reproductive health coverage information in the SBCs. This basic information should include whether abortions are covered, cost-sharing amounts or ranges, and any limitations on coverage. Plan documents should clearly establish whether they cover medication, aspiration, and surgical abortions, as well as inpatient versus outpatient care for abortions. Following such distinctions, qualified health plans should assign cost-sharing requirements based on the type of abortion and the settings in which they take place. Additionally, QHPs should include links to their plan documents where consumers can find more information about coverage.

Qualified health plans that do not cover abortions should indicate the exclusion of coverage both in the “Limitations and Exceptions” column as well as in the “Services Your Plan Does Not Cover” section of the SBCs.

Conclusion

Abortion is essential health care and a time-sensitive intervention. Therefore, plans should cover all abortions and clearly define the nature of such coverage in their plan documents, principally in the Summaries of Benefits and Evidence of Coverage, so that consumers can have immediate and easy access to this information. Plans should cease from using terminology that stigmatizes and confuses consumers seeking abortion coverage, like “therapeutic,” “voluntary,” or “elective.” In this addendum to our report, “Beyond the Law: The Challenge of Abortion Coverage in the Marketplaces,” NHeLP recommends concrete state and plan actions to improve coverage and communication of such coverage to all consumers.

Appendix 1: Template Summary of Benefits and Evidence of Coverage

Common Medical Event	Services You May Need	What You will Pay		Limitations, Exceptions and Other Important Information
		In Network	Out of Network	
If You're Pregnant	Prenatal Office Visits			Cost-sharing does not apply for preventive care. May include tests and services described elsewhere in the SBCs (i.e. ultrasounds)
	Abortions (incl. medication, aspiration, surgical)			
	Child birth/delivery professional services			
	Childbirth/delivery facility services			

ENDNOTES

- ¹ See Rachel Jones & Jenna Jerman, *Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014*, AM. J. OF PUB. HEALTH (2017). Use of the term “women” is intended to be an inclusive definition of women to encompass transwomen, genderqueer women, and gender nonconforming individuals who were born with female body parts.
- ² See Kaiser Fam. Found., *Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans* (June 24, 2019), <https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-Marketplace-plans-and-private-plans/>; See, also, Guttmacher Inst. *Restrictions on Private Insurance Coverage of Abortion: A Danger to Abortion Access and Better U.S. Health Coverage* (June 6, 2018), <https://www.guttmacher.org/gpr/2018/06/restrictions-private-insurance-coverage-abortion-danger-abortion-access-and-better-us>. See also, Guttmacher Inst., *Restricting Insurance Coverage of Abortion* (Sept. 1, 2018), <https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion>.
- ³ See Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, AM. J. OF PUB. HEALTH (2018), <https://www.ncbi.nlm.nih.gov/pubmed/29345993>.
- ⁴ See, e.g., The Am. C. of Obstetricians & Gynecologists, *Facts are Important: Abortion Care Later in Pregnancy is Important to Women’s Health* (Feb. 2019), https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/Facts-Are-Important_Abortion-Care-Later-In-Pregnancy-February-2019-College.pdf?dmc=1&ts=20190416T1539370567
- ⁵ See *supra* note 2, Kaiser Fam. Found., *Coverage for Abortion Services*.
- ⁶ See, e.g., Kinsey Hasstedt, *Abortion Coverage Under the Affordable Care Act: The Laws Tell Only Half the Story*, 17 GUTTMACHER POL’Y REV. 1 (Mar. 13, 2014) <https://www.guttmacher.org/gpr/2014/03/abortion-coverage-under-affordable-care-act-laws-tell-only-half-story>.
- ⁷ For more information about the Essential Health Benefit update process, please visit <https://healthlaw.org/essential-health-benefits/>.
- ⁸ 45 C.F.R. Part 147, 80 Fed. Reg. 34292, 77 Fed Register 8706.
- ⁹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (Mar. 23, 2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (Mar. 30, 2010).
- ¹⁰ The Am. C. of Obstetricians & Gynecologists, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak>.
- ¹¹ Text - H.R.3358 - 115th Congress (2017-2018): Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2018 (2017), <https://www.congress.gov/bill/115th-congress/house-bill/3358/text>. Since 1976, an annual appropriations bill rider known as the Hyde Amendment has restricted federal funding for abortion services except in the narrow circumstances of rape, incest, or life endangerment.
- ¹² See Fabiola Carrión & Alexis Robles, “Beyond the Law: The Challenge of Abortion Coverage in the Marketplaces” (Aug. 7, 2019), <https://healthlaw.org/resource/beyond-the-law-the-challenge-of-marketplace-coverage-of-abortions/>.